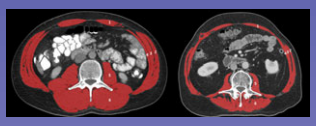
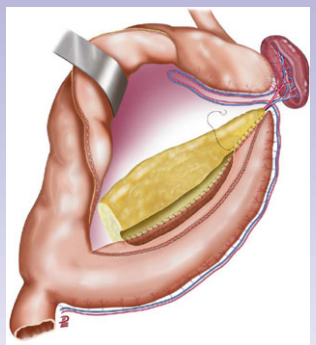
Highlights in this issue



Coelen *et al*., p. 520

Spelt *et al*., p. 529



Fernández-Cruz *et al*., p. 559

Radiation therapy and pancreatic cancer

When ESPAC-1 suggested that post-operative chemoradiation had a deleterious effect on survival after resection of pancreatic adenocarcinoma (PDAC), the world noticed. True or not, that collided with the ambitions of pre-operative radiation, especially as part of a neoadjuvant strategy to attack borderline resectable PDAC tumors. And so, what happened? *Burke et al.* evaluate trends in the use of radiation for PDAC over a 10-year period using the SEER database. The use of post-operative radiation therapy has appeared to decline between 2001 and 2010. That said however, the authors do reveal a survival benefit for post-operative radiation during the study period. The biggest test of radiation as a local disease control modality comes through its preoperative use, and this appears to have increased according to this SEER evaluation. Its relative use (3.9%) remained low, but it did correlate with a survival advantage. The authors also found that pre-operative radiation was significantly associated with younger patients with advanced stage tumors. We do not though learn of the actual modality of radiation administered be it external beam or stereotactic. Going forward, this will matter given reports of the efficacy of stereotactic radiosurgery on disease control and reduction preoperatively and even margin rescue post-operatively. Also, the potential for tumor radio-sensitization with newer chemotherapy regimens (Folfirinox, Gemcitabine/Abraxane) is not detailed with this analysis. The treatment menu for PDAC continues to include radiation therapy. Abysmal survival data though suggest it remains part of our losing battle against this disease.

Mark Callery

How should giant symptomatic hepatic haemangiomas be managed?

In this month's issue of *HPB, Qiu et al.* present a remarkable series of 730 patients who underwent surgery for giant hepatic haemangiomas (GHH). GHH was defined as haemangioma from 5 to 15 cm. These patients were selected from a cohort of 2684 patients who were assessed for hepatic haemangioma. Indications for surgery included symptoms (57%), increasing size (23%), complications (10%) or uncertain diagnosis (6%). The question asked by the authors was whether enucleation or formal hepatic resection resulted in better outcomes for these patients. The decision with regard to surgical procedure was left to the discretion of the operating surgeon. Despite seemingly comparable groups preoperatively hepatic enucleation resulted in clinically significant reductions in operative time (150 versus 240 min), blood loss (400 versus 860 ml), autotransfusion (1.5 versus 3.5 units) and hospital stay (5.7 versus 8.6 days). In addition there was reduction in major complications (14% versus 20%) especially bile leaks (9% versus 16%) and ascites (9% versus 15%). There was no mortality in either group and reoperation rate was 1%. However 73 patients were excluded from analysis because they were deceased- no explanation was given for causes of death.

Perhaps however the most important part of this study was the quality of life (QoL) data. The SF-36 questionnaire was used to assess preoperative and postoperative QoL at 1, 3, 6 months. A 90% completion rate of the QoL assessment was achieved. This was then compared to the QoL of the normal Chinese population. Importantly for those readers who remain sceptical regarding the true benefit of such surgery, the QoL in this cohort of patients preoperatively was significantly lower than that of the control group but, by 6 months postoperatively, had improved to equal that of the control group. These data suggests that surgery made a significant impact on these patient's lives. Maybe the only criticism is that the follow up period of 6 months may be too short. However this is a small criticism for what is an extraordinary paper in terms of sheer numbers, early results and QoL outcomes. This paper is well worth a read especially for those surgeons in practices where these questions could never be answered due to lack of numbers.

Saxon Connor

The jury is still out on oral contraceptive withdrawal in focal nodular hyperplasia

Focal nodular hyperplasia is a benign liver tumour typically affecting young women of reproductive age. The lesions are usually easy to diagnose with modern contrast enhanced cross-sectional imaging, however, the management of these lesions remains controversial. Focal nodular hyperplasia rarely causes symptoms and many lesions are detected purely by coincidence. As a consequence of the lack of symptoms and the absence of risk of malignant transformation, surgery is not considered a mainstream treatment (unless there is diagnostic uncertainty). Attention has focused on the association between female sex hormones and focal nodular hyperplasia.

In this edition of *HPB, Chandrasegaram and colleagues* from Adelaide, Australia, have undertaken an analysis of estrogen receptor expression in tissue from patients who underwent either resection or biopsy of focal nodular hyperplasia and from surrounding non-lesional liver. What they found was a very high rate of expression of estrogen receptor in both focal nodular hyperplasia and non-lesional liver. By contrast progesterone receptor expression was low. This conflicts with a number of previous studies that reported low or variable estrogen expression in focal nodular hyperplasia.

The issue over whether women with focal nodular hyperplasia should be advised to stop taking the oral contraceptive pill (OCP) is still contentious. While the findings of this study support other data showing an association between estrogen and focal nodular hyperplasia, the sample size is quite small and the association is circumstantial rather than mechanistically proven. The OCP is a highly effective contraceptive and also has benefits in terms of regularizing women's hormonal cycles and these known benefits have to be balanced on an individual basis with a potential benefit of withdrawal in patients with focal nodular hyperplasia.

Stephen J Wigmore